AMENDED IN SENATE MAY 23, 2001

AMENDED IN SENATE MARCH 28, 2001

SENATE BILL No. 785

Introduced by Senator Ortiz

February 23, 2001

An act to amend Sections *12693.02,* 12693.14, 12693.32, 12693.43, 12693.615, and 12693.70 of, and to add Section 12693.756 to, the Insurance Code, relating to the Healthy Families Program.

LEGISLATIVE COUNSEL'S DIGEST

SB 785, as amended, Ortiz. Healthy Families Program.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to children less than 19 years of age who meet certain criteria, including having a gross household income equal to or less than 200% of the federal poverty level. Existing law requires program applicants to pay a family contribution for coverage. Existing law also requires the board to expand eligibility under the program to parents of uninsured children eligible under the program to the extent that federal financial participation is obtained. Existing law continuously appropriates money from the Healthy Families Fund for purposes of the implementation of the Healthy Families Program.

This bill would *expand the definition of applicant. The bill would* require the Healthy Families Program to expand eligibility to include uninsured parents of children eligible to receive coverage under the Healthy Families Program and to uninsured parents of children receiving no-cost Medi-Cal. This bill would impose a maximum copayment *or contribution* amount for these subscribers and would

allow the board to pay reenrollment fees to designated individuals and organizations if a subscriber was reenrolled in the program based on their assistance in helping the subscriber complete the annual eligibility review packet. The program provisions of the bill would not be implemented unless federal financial participation is obtained and funds are specifically appropriated for this purpose. This bill would also require the board to implement regulations necessary to carry out this expanded program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. *Section 12693.02 of the Insurance Code is amended to read:*

12693.02. (a) ''Applicant'' means a person over the age of 18 years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(b) ''Applicant'' also means any of the following:

(1) A person 18 years of age who is applying on his or her own behalf for coverage under the program.

(2) A person who is under 18 years of age and is an emancipated minor who is applying on his or her own behalf for coverage under the program.

(3) A minor who is not living in the home of a natural or adoptive parent, a legal guardian, or a caretaker relative, foster parent or stepparent, who is applying on his or her own behalf for coverage under the program.

(4) A minor who applies for coverage under the program on behalf of his or her child.

(5) A natural parent, adoptive parent, stepparent, legal guardian, or caretaker relative with whom the child resides, who is applying on his or her own behalf.

SEC. 2. Section 12693.14 of the Insurance Code is amended to read:

12693.14. ''Subscriber'' means an applicant who is eligible for and participates in the purchasing pool component of the program.

~~SEC. 2.~~

SEC. 3. Section 12693.32 of the Insurance Code is amended to read:

12693.32. (a) (1) The board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(2) The board may also pay designated individuals or organizations a reenrollment fee, if the designated individual or organization assists a subscriber in completing the annual eligibility review packet and the subscriber is reenrolled as a result of the submission of the completed packet. This paragraph shall be implemented only to the extent that federal financial participation is obtained and funds are appropriated for this purpose. No appropriation shall be made for the purpose of this paragraph by Section 12693.96.

(b) The board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment and rules necessary to assure the integrity of the payment process.

(c) The board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.

~~SEC. 3.~~

SEC. 4. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) ~~For~~ *Seven dollars ($7) per child and ten dollars ($10) per adult with a maximum required contribution of thirty-four dollars ($34) per month per family for* applicants with annual household incomes up to and including 150 percent of the federal poverty level~~, no family contribution is required~~.

(2) Nine dollars ($9) per child and twenty dollars ($20) per adult with a maximum required contribution of fifty-eight dollars ($58) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 250 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area which has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to ~~six~~ *the following:*

(1) A family contribution of four dollars ($4) per child and seven dollars ($7) per adult with a maximum required contribution of twenty-two dollars ($22) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child and seventeen dollars ($17) per adult with a maximum required contribution of forty-six dollars

($46) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 250 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

~~SEC. 4.~~

SEC. 5. Section 12693.615 of the Insurance Code is amended to read:

12693.615. (a) The board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels established for state employees, effective January 1, 1998, through the Public Employees' Retirement System. Under no circumstances shall copayments exceed the copayment level established for state employees, effective, January 1, 1998, through the Public Employees' Retirement System. Total annual copayments charged to child subscribers shall not exceed two hundred fifty dollars ($250) per family. Total annual copayments charged to parent subscribers shall not exceed two hundred fifty dollars ($250) per family. The board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The board shall track the number of subscribers who meet the copayment maximum in each year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.

(b) No deductibles shall be charged to subscribers for health benefits.

(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.

(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.

(e) There shall be no variations in rates charged to subscribers including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that shall be permitted is that which is expressly authorized by Section 12693.43.

(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.

(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.

(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).

~~SEC. 5.~~

SEC. 6. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet any of the requirements in Section 12693.756 or all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the

program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) If the applicant is applying for the purchasing pool, and does not have a family contribution sponsor the applicant shall pay the first month's family contribution and agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

~~SEC. 6.~~

SEC. 7. Section 12693.756 is added to the Insurance Code, to read:

12693.756. Commencing on or after July 1, 2001, and upon receipt of any necessary federal waivers the board shall expand eligibility under this part to include uninsured parents of children eligible to receive coverage under the Healthy Families Program. Program eligibility and benefits offered to this new group shall be provided in accordance with this part. Uninsured parents of children receiving no-cost Medi-Cal shall also be eligible for coverage under this part. Program eligibility and benefits offered

to uninsured parents of children receiving Medi-Cal shall be provided in accordance with this part. This section shall be implemented only to the extent that federal financial participation is obtained and funds are appropriated for this purpose. No appropriation shall be made for the purpose of this section by Section 12693.96. The board shall adopt regulations necessary to implement this expanded program.

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